ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

APPLICATION FOR ELIGIBILITY DETERMINATION

When applying for services from the division of developmental disabilities (DDD), the **applicant** *(your child or person needing supports and services)* will need to provide the following information:

- Provide proof of citizen/lawful presence in the United States (ex: U.S. birth certificate, refugee, legal status, etc)
- Provide guardianship documents (if applicable: for individuals applying for services in your care)
- Copy of all medical insurance cards (front/back)
- Provide documentation of one of DDD's 4 qualifying disabilities
  - **(1) Autism spectrum disorder (2) cerebral palsy (3) intellectual (cognitive) disability (4) epilepsy or be at-risk for one of them**
- To prevent a delay in a decision, please submit additional documentation via email (dddapply@azdes.gov), mail or in person:

Flagstaff	**Chandler**	**Phoenix** (Central)	**Phoenix** (West)	**Tucson**
1701 N. 4th St. Flagstaff, AZ 86004	125 E Elliot Rd., Chandler, AZ 85225	11420 N. 19TH Ave. Phoenix, AZ 85029	4622 W. Indian School Rd., Ste. D-12 Phoenix, AZ 85031	6740 S Tucson Blvd. Tucson, AZ 85756
Fax: 928-773-8495	Fax: 480-926-5172	Fax: 602-542-0700	Fax: 602-774-9428	Fax: 520-638-2599

SECTION A. (Applicant Information)

Name _____ Date of Birth _____ Sex ☐ Male ☐ Female

AHCCCS A Number *(If Applicable)* _____ Primary Language: _____

Home Address *(No., Street)* _____

City _____ State _____ ZIP Code _____

Phone: _____ Ethnicity: _____ Tribe *(If Applicable)*: _____

Mailing Address *(If Applicable)* _____

City _____ State _____ ZIP Code _____

Contact Preference: ☐ Phone ☐ Email ☐ Both _____

Do you want to register to vote? ☐ Yes ☐ No

Does the applicant have documentation that supports one of the four diagnoses above? ☐ Yes ☐ No

(If yes, please list the professionals below that can assist with providing records. If no, please apply when you are ready.)

SECTION A.1

PROFESSIONALS WHO CAN PROVIDE RECORDS FOR ALL QUALIFYING DISABILITIES (Examples: Licensed psychologist, school psychologist, psychiatrist, pediatrician, neurologist, early intervention team, etc.) *Professionals accepted vary by disability. Ask your eligibility specialist if you have questions.*

Names and Contact Information	Type of Professional	Date of Evaluation

SECTION B. (Parent/Foster parent, if applicable)

Name _____

Relationship _____ Phone: _____

Address *(if different than applicant)* _____ Alt: _____

City _____ State _____ ZIP Code _____

See page 3 or 4 for EOE/ADA/LEP/GINA disclosures

Email: _____ Best Way to Contact you: _____

Legal Guardian Name *(If Different Than Above):* _____

Relationship _____ Phone: _____

Address _____

City _____ State _____ ZIP Code _____

(Legal guardian is a person who is appointed by a judge.)

SECTION C. Health Insurance

Type of Coverage (private, public, etc.)	Name of Health Plan	Policy Holder Name	ID/Group# and Policy#	Effective Date	Policy Holder's Date of Birth

SECTION D. (Early Intervention and Educational History – if Applicable)

Early Intervention Program State or School Name & School District	Type of Support (services or type of plan such as Individual Education Plan or 504 Plan)	Dates Attended

By signing below, I agree that:

- I am applying as a or for the person named above who is a resident of the State of Arizona.
- I have been informed of the services provided by this agency.
- I understand that if I am referred to AHCCCS for an ALTCS eligibility determination, I must cooperate in this determination process.
- As part of my application to this division, I have been informed of the DDD eligibility criteria and of my rights relevant to the application process.
- Applicants are required to assign rights to insurance benefits in accordance with R6-6-1303. If I am eligible and assigned to services, I authorize the release of information necessary to file a claim to my insurance company.
- I attest that everything I have stated in this application is true.

Who can sign the application?

- An applicant over 18 years of age without a court appointed legal guardian
- A biological or adoptive parent applying for a minor child
- A Case Manager from the Department of Child Safety, for children in foster care (need to have documents of guardianship)
- A legal guardian, appointed by a court (need to have documents of guardianship)

Name *(Please print)* _____

Relationship to Applicant *(i.e. parent, court appointed guardian, self)* _____

Responsible Person's Signature _____ Date _____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Health Insurance Portability and Accountability Act (HIPAA) Act of 1996 45 C.F.R. 164.508

Name of Individual/Client Whose Health Information will be shared *(Last, First, Middle)*

_____ Date of Birth _____

Describe what this information will be used for and why it is needed:

I authorize **Arizona Department Of Economic Security, Division Of Developmental Disabilities (DDD)** to disclose (share) protected health information described above to the individual/agency below.

Individual/Agency Requesting or Needing Information

_____ Date of Request _____

By signing this Authorization, I understand that:

I understand that once the records and information authorized herein are disclosed to entities or persons outside of DDD, they could be redisclosed by the recipient(s) and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. However, DES/DDD service providers generally are bound by contract and law to maintain the confidentiality of the health and other information received, especially that relating to HIV infection, AIDS or AIDS-related conditions, and psychological or psychiatric conditions.

I do not have to sign this authorization. I understand that a health care provider or health plan may not condition treatment, payment, enrollment or eligibility in a health plan or eligibility for health care benefits on my signing this authorization except as provided under state or federal law.

- I may have a copy of this document.
- I may revoke this authorization at any time, by sending written notification of the revocation; except to the extent that the disclosed authorization has been acted upon.
- A copy of this authorization shall be as valid as the original.
- Copy fees will not be reimbursed by the Division.
- This authorization shall expire a year from the date below.

Printed Name of Parent or Legal Guardian _____

Signature of Parent or Legal Guardian _____ Date of Authorization _____

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities (DDD)

AUTHORIZATION FOR RELEASE OF INFORMATION

Individual's Full Name *(Last, First, Middle)* _____ Date of Birth _____

I give permission for the following entity to share my protected health information:

Medical Professional/Agency/Educational Setting/Other

_____ Date of Request _____

To the Division of Developmental Disabilities:

Address *(No., Street)* _____

City _____ State _____ ZIP Code _____

Phone No. _____ Fax No. (If Faxing) _____

I allow the protected health information checked below to be shared with the medical professional, agency, educational setting or other listed above:

- ☐ Physician Records
- ☐ Newborn Records
- ☐ Labor, Birth & Delivery Records
- ☐ Audiology Records/Reports
- ☐ Psychological Reports
- ☐ Occupational Therapy Reports
- ☐ Speech and Language Reports
- ☐ Physical Therapy Reports
- ☐ Mental Health Records
- ☐ Latest 504 Plan or Individual Education Plan and Evaluation Report
- ☐ Other *(Specify)*: _____

This disclosure is being made at my request, and I choose not to state the reason for this disclosure. Information will be used to determine eligibility for the Division of Developmental Disabilities. This authorization shall expire a year from the date below.

I understand that once the records and information authorized herein are disclosed to entities or persons outside of DDD, they could be redisclosed by the recipient(s) and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996. However, DES/DDD service providers generally are bound by contract and law to maintain the confidentiality of the health and other information received, especially that relating to HIV infection, AIDS or AIDS-related conditions, and psychological or psychiatric conditions.

By signing this **Authorization**, I understand that:

- I may refuse to sign this authorization; however, I understand that the DDD may not be able to determine eligible for services.
- I may inspect or copy any information to be disclosed under this authorization.
- I may have a copy of this document.
- I may revoke this authorization at any time, by sending written notification of the revocation; except to the extent that the disclosed authorization has been acted upon.
- A copy of this authorization shall be as valid as the original.
- Copy fees will not be reimbursed by the Division.

Printed Name of Parent or Legal Guardian _____

Signature of Parent or Legal Guardian _____ Date of Authorization _____